specialized hospitals are exempt from the county target ceiling. The facility specific target ceiling shall apply to all hospitals except rural and specialty psychiatric hospitals.

D. The initial reimbursement ceilings shall be determined prospectively and shall be effective from July 1, 1990, through December 31, 1990. For subsequent periods the reimbursement ceilings shall be effective from January 1 through June 30 and July 1 through December 31 of the appropriate years except as provided in H. below.

E. Changes in individual hospital per diem rates shall be effective from July 1 through December 31 and January 1 through June 30 of each year.

F. For the initial period, the last cost report received from each hospital as of March 31, 1990, shall be used to establish the reimbursement ceilings. For subsequent periods, all cost reports postmarked by March 31 and September 30 and received by AHCA by April 15 and October 15 respectively shall be used to establish the reimbursement ceilings. For the initial period within 20 days after publication, a public hearing, if requested, shall be held so that interested members of the public shall be afforded the opportunity to review and comment on the proposed reimbursement ceilings. Subsequent rate periods shall not be automatically subject to public hearing.

G. For subsequent periods, all cost reports received by AHCA as of each April 15 and October 15 shall be used to establish the reimbursement ceilings. Providers shall be notified of the new reimbursement ceiling and rates prior to each June 1 and December 1.

H. The prospectively determined individual hospital's rate shall be adjusted only under the following circumstances:

1. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.

2. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond 3 years of the effective date the rate was established, or if the change is not material.

3. Further desk or on-site audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports.

~~4. A hospital offers to the purchasers of health care services new or expanded services approved by the certificate of need process, or discontinues a service that would materially affect the prospective per diem reimbursement rate currently in effect for the hospital. Within 60 days after the implementation of a new, expanded, or discontinued service, the hospital shall submit budget data that shall take into consideration new, expanded, or discontinued services. Such data shall be related to the data submitted for certificate of need approval and shall be desk audited by AHCA to determine if such costs are allowable in accordance with Section III of this plan. Upon completion of the desk audit, a new reimbursement rate shall be established. In the event that the change would result in a lower per diem, failure to submit budget data within 60 days shall require disallowance of all direct expenses associated with new, expanded, or discontinued services.~~

~~5. A hospital makes certificate of need approved capital improvements subsequent to the establishment of the per diem rate, or a hospital incurs costs for capital improvements due to certification or licensure requirements implemented subsequent to the establishment of the per diem rate. Within 60 days after such an event, the hospital shall submit budget data that shall take into consideration new, expanded, or discontinued services. Such data shall be related to the data submitted for certificate of~~

~~need approval and shall be desk audited by AHCA to determine if such costs are allowable in accordance with Section III of this plan.~~

4.~~6~~. Where a hospital's cost report contains a partial period's costs for new services or a capital improvement, the hospital shall attach for the Medicaid Cost Reimbursement section's consideration a 12-month projection of costs for the new service or capital improvement.

5.~~7~~. The charge structure of a hospital changes and invalidates the application of the lower of cost or charges limitations.

I. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with 59-1.018 (4), F.A.C., and Section 120.57, Florida Statutes.

J. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling established.

K. The agency shall distribute monies as appropriated to hospitals providing a disproportionate share of Medicaid or charity care services by increasing Medicaid payments to hospitals as required by Section 1923 of the Act.

L. The agency shall distribute monies as appropriated to hospitals determined to be disproportionate share providers by allowing for an outlier adjustment in Medicaid payment amounts for medically necessary inpatient hospital's services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age as required by Section 1923 of the Act.

V. Methods

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual hospital reimbursement rates.

A. Setting Reimbursement Ceilings for Inpatient Variable Cost.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:
   a. To reflect the results of desk audits;
   b. To compensate for new or expanded CON approved services, or discontinued services not accounted for in the reporting year. To be included, the hospital shall identify and submit budget data that shall take into consideration new and expanded services within 60 days after such services changed.
   c. To exclude from the allowable cost, any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.
2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 (1995).
3. Determine allowable Medicaid variable costs defined in Section X of this plan.
4. Adjust allowable Medicaid variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30, or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the latest available projections as of March 31 or September 30 for the Data Resources Incorporated (DRI) National and Regional Hospital Input Price Indices as detailed in Appendix A.
5. Divide the inflated allowable Medicaid variable costs by the latest available health, recreation and personal services component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.
6. Divide the results of Step 5 for each hospital by the sum of its Medicaid regular inpatient days plus Medicaid non-concurrent nursery days resulting in a variable cost per diem rate. Medicaid non-concurrent nursery days are

inpatient nursery days for a Medicaid eligible newborn whose mother is not an inpatient in the same hospital at the same time.

7. Array the per diem rates in Step 6 from the lowest to the highest rate for all general hospitals within the State with the associated Medicaid patient days.

8. For general hospitals in a county, set the county ceiling for variable costs at the lower of:

   a. The cost based county ceiling which is the per diem rate associated with the 70th percentile of Medicaid days from Step 7 times the FPLI component utilized in Step 5 for the county;

   b. The target county ceiling that is the prior January rate semester county ceiling plus an annually adjusted factor using the DRI inflation table. Effective July 1, 1995, the DRI inflation factor is 3.47 percent. With the adjustment of this DRI factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year.

9. The reimbursement county ceilings in V.A.8., above, shall not apply to specialized, statutory teaching or rural hospitals. For hospitals

participating in the Florida Medicaid Program that are located out of State, the FPLI used shall be equal to 1.00.

B. Setting Reimbursement Ceilings for Fixed Cost

1. Compute the fixed costs per diem rate for each hospital by dividing the Medicaid depreciation by the total Medicaid days.

2. Calculate the fixed cost ceiling for each hospital by multiplying Step 1 by 80%. This fixed cost ceiling shall not apply to rural hospitals and specialized psychiatric hospitals.

C. Setting Individual Hospital Rates.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:

   a. To reflect the results of desk reviews or audits;

   b. To compensate for new or expanded CON approved services, or discontinued services not accounted for in the reporting year. To be included, the hospital must identify and submit budget data within 60 days after such services changed.

   c. To exclude from the allowable cost, any gains and losses resulting from a change of ownership and included in clearly marked "Final" cost reports.

2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 (1995).

3. Determine allowable Medicaid variable costs as in V.A.3.

4. Adjust allowable Medicaid variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30 or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the latest available projections as of March 31 or

September 30 for the DRI National and Regional Hospital Input Price Index as detailed in Appendix A.

5. The variable cost per diem shall be the lessor of:

   a. The inflated allowable Medicaid variable costs divided by the sum of Medicaid inpatient days plus Medicaid non-concurrent nursery days for the hospital, or

   b. The facility specific target ceiling that is the prior January rate semester variable cost per diem plus an annually adjusted factor using the DRI inflation table. Effective July 1, 1995, the DRI inflation factor is 3.47 percent. With the adjustment of this DRI factor, the allowable rate of increase shall be 2.2 percent. Effective July 1, 1996, and for subsequent state fiscal years, the allowable rate of increase shall be calculated by an amount derived from the DRI inflation index described in appendix A. The allowable rate of increase shall be calculated by dividing the inflation index value for the midpoint of the next state fiscal year by the inflation index value for the midpoint of the current state fiscal year and then multiply this amount by 63.4 percent. The allowable rate of increase shall be recalculated for each July rate setting period and shall be the same during the remainder of the state fiscal year. The facility specific target ceiling shall apply to all hospitals except rural and specialized psychiatric hospitals.

6. a. Establish the variable costs component of the per diem as the lower of the result of Step 5 or the reimbursement ceiling determined under V.A.8. for the county in which the hospital is located.

b. A temporary exemption from the county ceiling for a period not to exceed 12 months shall be granted to an in-state general hospital by AHCA if all of the following criteria are met:

(1) The hospital has been voluntarily disenrolled for a period of not less than 180 days in the 365 days immediately prior to the date of application for this exemption. The hospital shall have been a fully participating Medicaid provider prior to their last disenrollment;

(2) During the 6-month period prior to the last voluntary disenrollment, the hospital provided the largest proportionate share of Medicaid services of all hospitals in the county, as measured by total Medicaid costs for the period;

(3) On the date of the last voluntary disenrollment, less than 51 percent of the private, non-governmental hospitals in the county were participating in the Medicaid Program;

(4) During the 6-month period prior to the last voluntary disenrollment, the hospital treated over 50 percent of the indigent patients in the county who required hospital services during that time period. Indigent patients are those eligible for Medicaid or classified as indigent by a county-approved social services or welfare program.

If an exemption is granted to a hospital, the hospital shall agree to remain in the Medicaid Program and accept Medicaid eligible patients for a period of not less than 3 years from the date of re-enrollment. The exemption shall be granted to a hospital only once since original construction, regardless of changes in ownership or control. If a hospital disenrolls

prior to the fulfillment of its 3-year enrollment agreement, AHCA shall recoup funds paid to the hospital in excess of the amount that would have been paid if the county ceiling had been imposed during the first 12 months which shall be defined as excess amount, according to the following schedule. If a hospital is re-enrolled under the ceiling exemption provision for less than 12 months, the Agency shall recoup 100 percent of the excess amount. For each month of enrollment subsequent to the first year of re-enrollment under the ceiling exemption provision, 1/24 of the excess amount shall be no longer owed so that after 36 months of re enrollment the Department shall recoup none of the excess amount.

Example 1: Hospital reenrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on November 30, 1984. During this 5-month period the hospital receives an excess amount of $10,000. Recoupment would be calculated as:

$10,000 - ((0 months x 1/24) x (10,000)) = $10,000

Example 2: Hospital re-enrolls under the ceiling exemption provision on July 1, 1984, and disenrolls on December 31, 1986. During the first 12 months the hospital receives an excess amount of $20,000. Recoupment would be calculated as:

$20,000 - ((18 months x 1/24) x (20,000)) = $ 5,000

7. Compute the fixed costs component of the per diem by dividing the Medicaid depreciation by the total Medicaid days.

8. Established the fixed costs component of the per diem as the lower of Step 7 or the reimbursement ceiling determined under V.B.2.

9. Calculate the overall per diem by adding the results of Steps 6 and 8.

10. Set the per diem rate for the hospital as the lower of the result of Step 9 or the result of inflated Medicaid charges divided by total Medicaid days.

11. For hospitals with less than 200 total Medicaid patient days, or less than 20 Medicaid patient admissions, the per diem rate shall be computed using the principles outlined in Steps 1 through 10 above, but total costs, charges, and days shall be utilized, instead of the Medicaid apportioned costs, charges and days.

D. Determination of Individual Hospital Regular Disproportionate Share Payments for Disproportionate Share Hospitals.

1. In order to qualify for reimbursement, a hospital shall meet either of the minimum federal requirements specified in Section 1923 of the Act. The Act specifies that hospitals must meet one of the following requirements:

   a. The Medicaid inpatient utilization rate is greater than one standard deviation above the statewide mean, or;

   b. The low-income utilization rate is at least 25%.

2. Also, a hospital shall qualify for reimbursement if its total Medicaid days when combined with its total charity care days equals or exceeds 7 percent of its total adjusted patient days, and its total charity care days weighted by 4.5 plus total Medicaid days weighted by 1 is equal to or greater than 10 percent of total adjusted patient days, or if all the requirements in Section E.1. a-h are satisfied.

3. Additionally, the Act specifies that in order for the hospital to qualify for reimbursement, the hospital must have at least two obstetricians or physicians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. This does not apply to hospitals where:

   a. The inpatients are predominantly individuals under 18 years of age, or